Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number:_____

Report for the Month of: _____

Monthly Counseling Activity Report (Part I)

No.	Client Name	Ethnic Code	Lab Results	Lab Number	Date Counseled	Counseling Site	County	Not Counseled Reason	Counselor Name
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									

*Not Counseled Reason Codes: AC = Already Counseled NR = No Response M/UTL = Moved/ Unable to Locate D = Declined

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Monthly Counseling Activity Report (Part II)

Report for the Month of: _____

Client Demographic Changes

Clt. No.	Lab Number	Former Name	New Name	Former Address	New Address	New Phone Number

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Confirmatory Testing Report

No.	Date	Name of Person Being Tested	Date of Birth	Reason for Testing				Comments
				Newborn Repeat Test	Newborn Family Member Referral	Individual Request for Screening	Other	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Programmatic Literature and Data Review Report

Date	Type of Literature /Data Reviewed	How does the literature or data reviewed relate to sickle cell and/or other hemoglobin disorders? How will the literature and/or data be used?

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Counselor Recruitment Report

Name	Address	Telephone Number	Assigned County	Training Completed?		Comments
				Yes	No	

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Public Education Activities Report

Date	Name/Address of Person Requesting Activity	Telephone Number	Type of Audience					Service Provided
			Adults	Children	Mixed	Medical	Health Fair	

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
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Report for the Month of: _____

Linkage with Other Agencies Report

Date	Linkage	Type of Linkage	How will the linkage with this agency benefit the sickle cell anemia program in relation to sickle cell anemia?

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Monthly Demographics Report (Part I)
Counseling Data by County

County	Counseled	Client Moved/UTL	No Response	Already Counseled	Other	**TOTALS**
Apache						
Cochise						
Coconino						
Gila						
Graham						
Greenlee						
La Paz						
Maricopa						
Mohave						
Navajo						
Pima						
Pinal						
Santa Cruz						
Yavapai						
Yuma						
TOTALS						

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Report for the Month of: _____

Monthly Demographic Report (Part II)
Lab Results by Ethnicity

Lab Results	1 Caucasian	2 African American	3 Asian	4 American Indian	5 Hispanic	6 Other	TOTALS
FAS							
FAC							
AS							
AC							
FA+D/G							
FAE/O							
AF							
FAU(S)							
FAU(F)							
FSC							
SC							
E							
SF							
O Padova							
SD							
FAJ or N							
A+G San J							
FAS +UN							
AE+F							
FSA							
C/Other							
TOTALS							

Arizona Department of Health Services
Sickle Cell Anemia Program
Family Service Plan

Part 1
Referral for Counseling

(Insert name and address of Contractor)

(Insert telephone number of Contractor)

Name: ____________ DOB: ____________ ☐ Male ☐ Female Telephone ____________

Address: ____________ City: ____________ Arizona Zip: ____________

Parent's Full Name: ____________ Parental Heritage (Father) ____________ (Mother) ____________

Lab Result ____________ Date ____________ Lab No. ____________ Testing Agency: ____________

FAMILY					
NAME	RELATIONSHIP	DOB	LAB RESULTS	DATE TESTED	AGENCY

COUNSELING COMPLETED ☐ YES ☐ NO ☐ NO SHOW

COMMENTS: ____________

DATE COUNSELED ____________

COUNSELING SITE ____________

MEDICAL SERVICES ____________

OTHER RELATIVES WITH SCA? ☐ YES ☐ NO

COUNSELOR SIGNATURE

COUNSELEE SIGNATURE

Arizona Department of Health Services
Sickle Cell Anemia Program
Family Service Plan
Part 2
Counseling Survey

Client's Name:_____ Date: _____
Person Counseled: _____ Relationship to Client: _____
Counselor: _____

1 A person with sickle cell trait (a) is a carrier of one normal gene (A) and one sickle gene (S); (b) has sickle cell disease; (c) is a carrier of two sickle genes (SS) and has sickle cell anemia.

2 The sickle cell gene affects (a) the white blood cells; (b) the hemoglobin inside the red blood cells (c) the iron within the red blood cell.

3 Having sickle cell trait (a) affects your health under normal circumstances; (b) is like having sickle cell anemia; (c) may affect your health under certain conditions.

4 Sickle cell trait/anemia is found in (a) only males; (b) only people of the Black race. (c) people of all races.

5 The reason that sickle cell trait is prevalent in the Malaria Belt is (a) because most people living in the area have dark skin. (b) because the climate is warmer; © because more people with the trait survived Malaria.

6 Sickle cell disease causes a person (a) no symptoms; (b) severe, life threatening symptoms; (c) mild symptoms such as joint pains, mild anemia (d) both B and C.

7 If both parents have sickle cell trait then (a) there is a 25% chance with each pregnancy that the child will be born with sickle cell anemia; (b) the first child will have sickle cell anemia and the rest won't; (c) every child WILL be a carrier.

8 If one parent has sickle cell trait and the other is normal (a) one child will have the sickle cell anemia; (b) all the children will be normal; (c) there is a 50% chance with each pregnancy that the child will be born with sickle cell trait and a 50% chance that the child will be born with normal hemoglobin.

9 The sickle cell trait with modern treatment can (a) change to a normal gene; (b) can never be changed; (c) can be prevented from being passed on to one's children.

10 A person who has sickle cell anemia (a) can engage in normal activities (b) can have children without sickle cell anemia; (c) may experience painful episodes requiring medical treatment; (d) all of the above.

11 Was the appointment at a time and place you agreed with? Yes ☐ No ☐

12 Was the information clearly presented in a language or manner that was useful to you? Yes ☐ No ☐

13 Are you interested in being linked to other services i.e. WIC, Food Stamps, Head Start, Family Support Groups, Referral for (*i.e. referral for screening, health care, food, clothing, etc.)* Yes ☐ No ☐
(If yes, complete Part 3 of Family Service Plan)
Comments:_____

_____

_____

_____

_____

_____

Client Signature _____

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: _____
Contract Number: _____

Family Service Plan (Part III)

Report for the Month of: _____

Individual/Family Needs Assessed, Referrals, and Follow-up Report

Date	Client Name and Address	Needs Assessed	Action Steps	Follow-Up Date	Case Status		Comments
					Open	Close	
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						
	Phone:						

Arizona Department of Health Services
Sickle Cell Anemia Program

Monthly Invoice

Invoice for the Month of : _____ 20_____

Bill to: Arizona Department of Health Services - Sickle Cell Anemia Program

ADHS Contractor: _____

ADHS Contract Number: _____

ADHS Purchase Order Number: _____

Request for Reimbursement for Program Administration and Counseling Services are as follows:

Program Administration Price per month = $ _____

Counseling Services:

_____ Level 1 (face to face) counseling sessions completed x $0000.00 per session = $ _____

_____ Level 2 (telephone) counseling sessions completed x $0000.00 per session = $ _____

Total Amount Requested for Program Administration and Counseling Services = $ _____

_____ _____
Signature of Person Authorized to Request Funds Date Submitted

_____ _____
Signature of Person Authorized to Approve Payment Date of Approval

Arizona Department of Health Services
Sickle Cell Anemia Program

Contractor: ____
Contract Number: ______________________________________

Sickle Cell Trait Counselors' Report

Part 1

Counselor Name: ______________________ Month: ______________ Year: _______

Total # Assigned: _______
Total # Completed: _______
Total # Given Test: _______
Total # 70% or More: _______
Total # Held Over: _______

Total # Declined: _______
Total # Moved/UTL: _______
Total # Already Counseled: _______
Total # No Response: _______

Client Name: ______________________ Lab #: ______________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:
Comments:
1 ______
2 ______
3 ______

Client Name: ______________________ Lab #: ______________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:
Comments:
1 ______
2 ______
3 ______

Client Name: ______________________ Lab #: ______________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:
Comments:
1 ______
2 ______
3 ______

Client Name: ______________________ Lab #: ______________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:
Comments:
1 ______
2 ______
3 ______

Arizona Department of Health Services
Sickle Cell Anemia Program
Sickle Cell Trait Counselors' Monthly Report (Part 1)
Month: _______________ ___________

Client Name: ________________________ Lab #: ________________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:

Comments: 1 ____ 2 ____ 3 ____

Client Name: ________________________ Lab #: ________________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:

Comments: 1 ____ 2 ____ 3 ____

Client Name: ________________________ Lab #: ________________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:

Comments: 1 ____ 2 ____ 3 ____

Client Name: ________________________ Lab #: ________________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:

Comments: 1 ____ 2 ____ 3 ____

Client Name: ________________________ Lab #: ________________________

Counseling Completed: ☐ Moved/UTL: ☐ Already Counseled: ☐ Held Over: ☐
Letter Sent/No Response: ☐ Declined: ☐ Attempts/Outcomes:

Comments: 1 ____ 2 ____ 3 ____

Arizona Department of Health Services
Sickle Cell Anemia Program

Sickle Cell Trait Counselors' Report
Part 2
Reimbursement Record

Counselor Name: _____ Month: _____ Year: _____

No.	Last Name of Client	Lab # of Clients Counseled	Type of Counseling: Level 1 (Face to Face) Level 2 (Telephone)	Rate Per Counseling Session	Total Mileage to and from Counseling Session
1				$	
2				$	
3				$	
4				$	
5				$	
6				$	
7				$	
8				$	
9				$	
10				$	
Number of Counseling Sessions Completed: _____				Amount for Counseling: $_____	Miles Incurred: _____

AMOUNT FOR COUNSELING:
_____ Face to Face @ $00.00 per session $_____
_____ Telephone Session(s) @ $00.00 per session $_____
TOTAL AMOUNT FOR COUNSELING $_____

MILEAGE:
_____ Miles incurred @ $:00 per mile $_____
TOTAL AMOUNT FOR MILEAGE $_____

REIMBURSEMENT FOR SUBSISTENCE (i.e. postage, long distance telephone)
TOTAL AMOUNT FOR SUBSISTENCE $_____

TOTAL AMOUNT FOR COUNSELING MILEAGE AND SUBSISTENCE $_____

EXPLANATIONS OR REMARKS: _____

I hereby certify that I have counseled the clients identified by the above specimen numbers; that the number of sessions and miles specified above were used in the performance of this counseling; that any amounts claimed for subsistence represent actual costs; that the amount shown herein is due for the period designated; and that no part of said amount has heretofore been claimed or paid to me.

COUNSELOR'S SIGNATURE: Date:

AUTHORIZED SIGNATURE: Date:

Arizona Department of Health Services
Sickle Cell Anemia Program

Business Continuity and Recovery Plan Training Log

Date	Staff	Title	Signature